Food and Drug Administration
Center for Food Safety and Applied Nutrition
Office of Special Nutritionals

ARMS#

13072

8 - OTHER

[redacted]

November 11, 1998

[redacted]

RE: [redacted] File

Dear Dr. [redacted]

The [redacted] is conducting an investigation of a report of abuse and neglect concerning the above-referenced child. It is our information that you have provided medical services for this child.

[redacted] is the social worker conducting this investigation. Pursuant to [redacted] I hereby request that this social worker be allowed to examine the records concerning this child. Please fax this information to the above named social worker at [redacted] as soon as possible or at your earliest convenience.

We sincerely appreciate your cooperation in this matter.

Sincerely,

[redacted]

[redacted]

CC# EDR-2789
CFSAN Project # 13072
11/23/98 EBB
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[redacted]

[redacted]

[redacted]

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient Name: [redacted] Social Security No.: [redacted]

Birthdate: [redacted] Date(s) of Treatment: 8/21-31/98

Information to be released from: Name/Agency: [redacted]

Address: [redacted]

[redacted]

Information to be released to: Name/Agency: U.S. Food & Drug Administration

Address: 5701 Executive Center Drive; Suite 104

12-14-98 Charlotte, NC 28213

attn: Eileen Bannerman

Purpose for Release:

☐ Continuity of Care ☐ Education Credit ☐ Legal Representation ☒ Other (specify) Complaint Investigation re. adverse event as noted

Information to be Released:

☐ Dates of Hospitalization(only)	☒ Psychiatric Evaluation	☐ Educational Assessment	☒ Consultation Reports
☒ Discharge Summary	☒ Psychological Evaluation	☐ School Records	☒ Medication Records
☒ History & Physical Exam	☒ Aftercare Plan	☒ Lab/X-ray Reports	☒ Progress Update

Other (specify) _____

I understand that information to be released may include information regarding drug abuse alcohol abuse psychological or psychiatric impairments, HIV and/or AIDS or physical conditions.

I certify this authorization is made voluntarily. I understand that the information to be released is protected under state and federal laws and cannot be redisclosed without my further written consent unless provided for by state and federal law.

I understand I may revoke this authorization at any time, except to the extent that action has already been taken. If not previously revoked, this consent will expire six months from date of signature.

[redacted]

Signature of Patient / Date

[redacted] 12/11/98 Father

Relationship

Signature of Witness

Released By [redacted] Date

Name & Title

000003

[redacted]

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[redacted]
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